# ADVENTIST DEVELOPMENT AND RELIEF AGENCY (ADRA- GUINEA/CONAKRY)

## CHILD SURVIVAL PROJECT (SMIS)
## Grant No 938-2000-A-0500-16
## SIGUIRI PREFECTURE
***FOURTH ANNUAL PROGRESS REPORT***
***October 2003-September 2004***


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# List of acronyms

| | |
|---|---|
| ADRA | Adventist Development and Relief Agency |
| AIDS | Acquired Immuno Deficiency Syndrome |
| ALK | Acceptable Level of Knowledge |
| BCC | Behavior Change Communication |
| CA | Community Agents |
| CS | Child Survival |
| DIP | Detailed Implementation Plan |
| DPS | Direction Prefectorale de la Sante (Director of Health for Prefecture) |
| EPI | Expanded Program for Immunization |
| FP | Family Planning |
| FY | Fiscal Year |
| GM | Growth Monitoring |
| HC | Health Center |
| HIV | Human Immunodeficiency Virus |
| HP | Health Post |
| HVT | Health Volunteer |
| MCH | Maternal and Child Health |
| MM | Moderate Malnutrition |
| MoH | Ministry Of Health |
| MPH | Master of Public Health |
| MURIGA | Mutuelles pour la réduction des Risques liées a la Grossesse et a l'Accouchement (Health Insurance Scheme) |
| NGO | Non Governmental Organization |
| NIDs | National Immunization Days |
| PADRAS | Projet pour l'Augmentation Des Ressources Alimentaires de Siguiri (ADRA Title II Food Program in Siguiri) |
| PDM | Positive Deviant Mother |
| PPSG | Projet Population Sante Genesique (Project for Population Genetic Health) |
| PRISM | Pour Renforcer les Interventions de Sante de reproduction et des MST/SIDA (To strengthen interventions in reproductive health and HIV/AIDS) |
| SM | Severe Malnutrition |
| STI | Sexually transmitted Infection |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid |
| USAID | United States Agency for International Development |
| VDC | Village Development Committee |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |

**Executive Summary**

In September 2004, ADRA child survival project in Guinea completed its fourth year of operations in the prefecture of Siguiri in the Upper Guinea region. The project area covers 6 sub-prefectures and 72 villages. The overall goal of the project is to improve the health of mothers and children 0-5 years. More specifically the project goals are to engender improved knowledge of good health behaviors, increased acceptance of good health practices and improved overall health of communities. The project intervenes in nutrition, vaccination, safe motherhood, malaria prevention and family planning.

In fiscal year 2004, the project completed the census of project beneficiaries, improved the norms of supervision, prepared for final evaluation and reinforced partnership with the MoH and other NGOs such as Save the Children and PRISM.

At the level of accomplishments ADRA CS project completed trainings of 216 religious leaders and 143 village development committees' members in family planning and re-trainings of 32 MoH staff in nutrition; 32 MoH staff in vaccination; 15 MoH staff and 70 TBAs in safe motherhood; 30 supervisors of community agents and 69 community agents in family planning.

Accomplishments in field activities include Behavior Change Communication in all project interventions; monthly growth monitoring and Hearth session in nutrition; participation in national immunization days and outreach activities in vaccination; completion of the installation of social insurance schemes in the 72 villages and the distribution of funds obtained to strengthen *Mutuelles*; the transfer of knowledge gained by religious leaders and community agents in family planning.

Another major accomplishment of the reporting year has been the implementation of recommendations/issues raised by the mid-term evaluation as mentioned in table 5 in the report.

Barriers to implementation of field activities include geographical constraints such as inaccessibility of some project areas during the rainy season and long distance from country office; technical constraints linked to the mobility of the community and economical constraint which are the pathology of poverty in the project zone.

ADRA's CS project in Siguiri was granted a one-year (October 2004-September 2005) costed extension from USAID and the Flex Fund for follow-on activities. During the year of follow on activities, the project will implement activities aimed at strengthening sustainability in collaboration with the MoH and the involvement of the communities. Family planning activities will be the other major area of intervention during fiscal year 2005.

## I. Introduction

ADRA has being implementing a four year (October 1, 2000- September 30, 2004) Child Survival (CS) project in the prefecture of Siguiri in the upper Guinea/Conakry region. Guinea's maternal and child health indicators are very low. According to the 1999 demographic health survey, infant mortality rate for Guinea was reported as 98/1000 live births. Upper Guinea was reported as 129/1000 live births. Child mortality rate in Guinea is reported nationwide as 177/1000, while upper Guinea reports 107/1000 live births. Maternal mortality at the country level is reported as 528/100000 live births. The leading causes of infant and child mortality in Guinea are vaccine preventable diseases (22%); malnutrition (20%); acute respiratory infections (16%) and malaria (11%).

The prefecture of Siguiri has 12 sub-prefectures and the child survival project covers half of those sub-prefectures (Doko, Franwalia, Kintinia, Niagassola, Norassoba and Siguiri center) and 72 districts (Annex A). The project interventions focus on the areas of nutrition, immunization, malaria prevention and safe motherhood with integration of education on family planning through the Flex Fund. The target population includes women of reproductive age and children 0-60 months.

The project goals are to engender improved knowledge of good health behaviors, increase acceptance of good health practices and improve the overall health of the target population.

Project strategies focus on BCC activities aimed at promoting the adoption of good health behaviors and practices; building capacity of MoH staff in order to improve the quality of services rendered by health centers/health posts and building capacity of the targeted communities to identify preventable diseases such as malaria and malnutrition.

The expected project impacts include a sustainable reduction in chronic malnutrition, a reduced incidence of vaccine preventable diseases, a reduction in maternal mortality and a reduction in malaria related mortality among children under five years old.

The CS project is funded by USAID and is in line with USAID/Guinea's Strategic Objective (SO 2) to "*increased utilization of FP/MCH and STI/AIDS prevention services and products*". The project contributes to the achievement of USAID/Guinea's four intermediate objectives which include:

- To increase access
- To improve quality
- To increase demand
- To improve coordination of FP/MCH and STI/AIDS prevention services and products.

This report focuses on activities completed from October 2003 to September 2004. More specifically the project will highlight main project accomplishments for each intervention describing what the project has done well and factors that have contributed to achieving these accomplishments. The report will also provide information on factors impeding progress as well as action taken to overcome these constraints. An important aspect of this report will be providing information on how the project has addressed issues or recommendations made by the midterm evaluation conducted in July 2003 as well as identifying/addressing the current expectations on progress towards phase out of activities. The program management system that includes administrative and financial management will be described and a timeline for the one year USAID/Guinea grant for follow-on activities will be provided.

## II. Program Accomplishments

ADRA Guinea Child Survival (CS) project has seen several accomplishments in this past year in the areas of administration and programs.

### A. Administrative

ADRA's child survival project administrative system did not have major changes during FY 2004. The office set up was already completed in previous years. Major logistics investments were not necessary during the fourth years of the life of the project. However, a new gatekeeper was hired in order to adjust the daily working hours of gatekeepers and have them work for eight hours like all other regular ADRA's employees.

### B. Programmatic

#### B.1. Census of project beneficiaries

A census aimed at knowing the real size of project beneficiaries was conducted in 2003 .This census was recommended by the mid-term evaluation as it appeared that the size of the target population was overestimated. In the Detailed Implementation Plan (DIP) a district was taken for a village whereas a district is composed of sectors or villages. Because of limited resources and lack of road infrastructure, the project only intervenes in the central area (or sector) of each district and not in all areas (sectors) surrounding a given district. The census revealed the actual population size of ADRA's CS to be 64,097 as opposed to the 167,000 mentioned in the DIP (see Annex B). Children 0-11 which represent 4% of total population are estimated at 2,564; children 0-3 years (7,917) and women of reproductive age (WRA) are 16024 (25%). Project results will be calculated using these figures. These corrected numbers were communicated to USAID and have been changed on the CSTS program tracking section of their web-site.

#### B.2. Preparing for final evaluation

In view of the final evaluation, which was scheduled for June 2004, the project team in collaboration with ADRA headquarters worked in April/May 2004 to prepare for the final evaluation. Concretely, ADRA headquarters provided the project staff with a questionnaire developed by Dr. Solomon Wako, ADRA International Director of Evaluation used for the baseline survey. Questions specifically targeting HIV/AIDS and the Flex Fund project were also added. This questionnaire was reviewed and translated in Malinke (the local language) at the project level and a consultant was hired to translate it from Malinke to French. The final evaluation was postponed because ADRA's CS project in Siguiri was granted a one-year (October 2004-September 2005) costed extension from USAID and the Flex Fund for follow-on activities.

#### B.3. Supervision

B.3.1. Strategy of supervision

The strategy for supervision involved dividing the six sub-prefectures into three zones. Each zone consists of two sub-prefectures and twenty four villages. Each zone is managed by one supervisor and four animators. This system allows monthly quantitative and qualitative supervision of field animators and VDCs by the three technical supervisors.

B.3.2. Reporting

The project has four different reporting mechanisms in place for follow up of field activities:

- Annual and quarterly reports prepared by the project Director, reviewed by the program Director and Country Director ADRA/Guinea. The report is then sent to the ADRA/HQ for further review and annual reports submitted to USAID.
- Monthly technical reports prepared by the technical supervisors responsible for the different technical areas of the project.
- Monthly supervision reports prepared by the technical supervisors responsible for each of the three zones of the project area. These reports provide results of supervision visits of field animators and VDCs.
- Monthly field reports prepared by the field animators. These reports reflect field activities conducted during the month.

B.3.3. Improvement of supervision

ADRA noticed that the amount of time given to field supervision did not allow supervisors to identify weaknesses and propose appropriate corrective measures. In addition, the ministry of health was not strongly committed in conducting regular field supervisions**.** A joint meeting between the CS project and the ministry of health was organized to find out solutions. Norms for supervision were consequently adjusted and improved during the reporting year (see Annex C).

Measures taken to improve the supervision system include organizing joint field supervisions with the ministry of health and increasing the number of days that supervisors were expected to spend for field supervisions from four to eight days per month. The adjustment in the amount of time aimed at allowing supervisors to cover one district per day rather than two to three districts per day like they used to do in the past. Another major action taken as far as the supervision system is concerned was the re-training of supervisors of TBAs (health centers agents) that took place February 23-24, 2004.

As a result of the change in the supervision system, the project was able to identify discordances between data provided by some field animators and what was really happening in the field. The new strategy that was put in place also enabled project supervisors to provide regular technical support to field animators particularly focusing on the areas of family planning and social health insurance schemes.

**B.4. Identification of female FP community agents**

During FY 2004, the project identified female FP community agents as a response to the request by FP users who expressed concerns about interacting with male FP agents. Currently, the project has a list of these female FP community agents and their training is scheduled for FY 2005.

**B.5. Partnership**

In terms of partnership, the project collaborated with the MoH, *PRISM* (NGO working in Guinea with a reproductive health focus), *Save the Children* and *PPSG* a world bank funded health project in Guinea as described below in section V II.D.

## C. Training

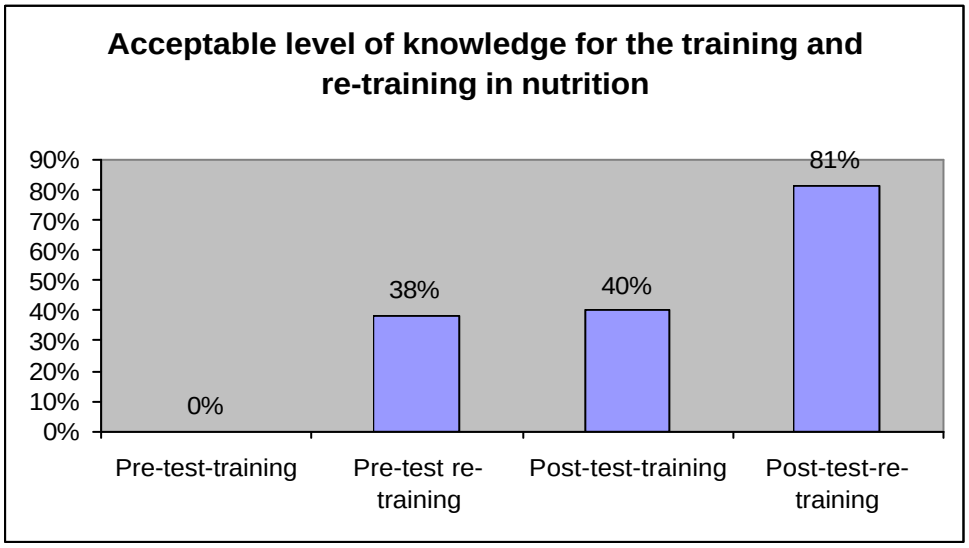
ADRA is using training/re-training in key child survival (CS) activities as the backbone of project strategies to attain its stated objectives. Training/re-training consists of eight training sessions that last for one week or less per session. ADRA is committed to doing all it can to ensure sustainability of project outcomes and re-trainings are particularly important during the last year of project implementation to attain this. During FY 2004 training and re-training activities were conducted in the areas of nutrition, vaccination, safe motherhood and family planning (FP) as seen in Table 1 and discussed under section C-1 to C-4 below. These training activities targeted participants from the community and the health center levels

### C.1. Nutrition

The re-training in nutrition was conducted in June 7-9, 2004. Beneficiaries from this training were key health staff of the 24 health posts (HP) and health agents from the 8 health centers in the project area. The aim of the re-training was to reinforce trainees with competencies that will enable them to provide even better preventive nutrition activities in their respective districts. The topics covered included: exclusive breastfeeding, food diversification, preparation of balance diets, identification of signs of malnutrition, causes and consequences of malnutrition, the nutrition of a pregnant woman, nutrition of a woman who breastfeeds, promotion of locally available foods, Hearth program and referral of severely malnourished children to health center/post.

Re-training was conducted by trainers from the prefectoral directorate for health or *Direction Prefectorale de la Sante* (DPS) with the support of project staff and used the training modules developed by the Ministry of Health of Guinea/Conakry. To assess the acquisition of knowledge, pre and post-tests were conducted and compared to the acceptable level of knowledge (ALK) standard indicator, which is 70%. Results from the pre-test showed that 38% (12/32) of all respondents had an ALK greater than 70%. Post-tests results showed that 81% (26/32) had an ALK greater than 70%. The difference in pre and post tests from training and the retraining was an increase in the ALK of 31% for the pre and 41% for the post as results for the training was 0% at pre and 40% at post tests.

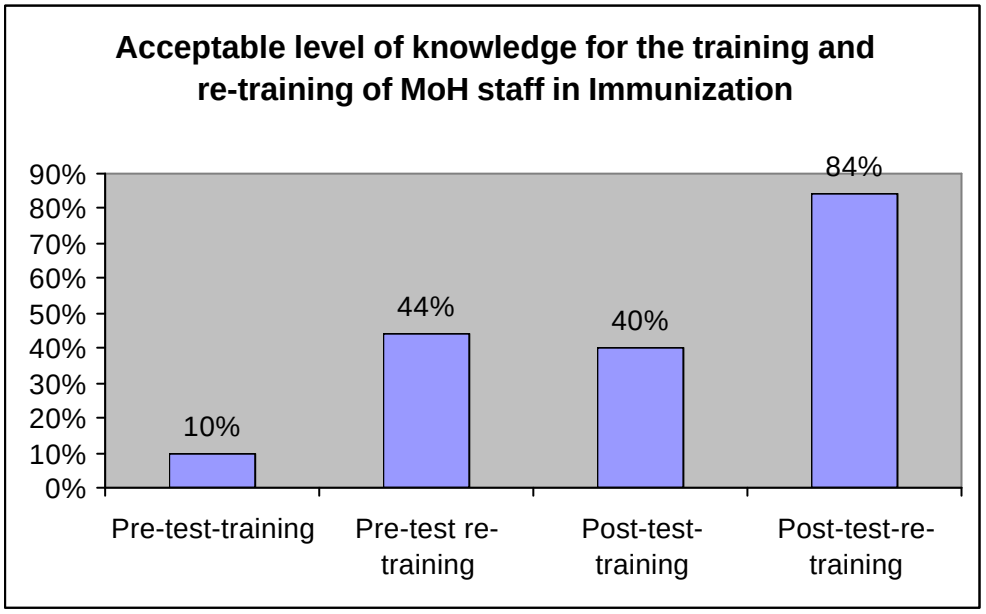
Graph 1: Results of pre and post tests for the trainings in nutrition



**C.2. Immunization**

The re-training on immunization was conducted at the same time that the re-training for nutrition targeting the same audience as described above. Trainers were from the prefectoral directorate for health. The training aimed at providing key health staff of the 24 health posts and health agents from the 8 health centers in the project area with competencies to conduct vaccination activities both at the health center level and in outreach locations. Topics covered included immunization protocols, cold chain maintenance, and transportation of vaccines; follow up of vaccines usage, planning and management of vaccination activities at the health center and in outreach locations and assessment of immunization coverage.
To assess the acquisition of knowledge, pre and post-tests were conducted and compared to the acceptable level of knowledge (ALK) standard indicator which is 70%. Results from the pre-test showed that 44% (14/32) of all respondents had an ALK greater than 70%. Post-tests results showed that 84% (27/32) had an ALK greater than 70%. The difference in pre and post tests from training and the retraining was an increase in the ALK of 44% for the pre and 44% for the post as results for the training was 0% at pre and 40% at post tests.

Graph 2: Results of pre and post tests for the trainings of MoH staff in immunization




**C.3. Safe motherhood**

Training in the area of safe motherhood took place in the second quarter of FY 2004 and focused on training of traditional births attendants (TBA) supervisors and TBAs themselves.

C.3.1. Re-training of TBAs supervisors—The re-training of TBAs supervisors took place from February 23-24, 2004. Fifteen TBA supervisors from all health centers in the project area were selected to be re-trained. The re-training of TBA supervisors was intended to provide them with refresher knowledge concerning their role in evaluating the quality of work done by TBAs and in identifying problems faced by TBAs while conducting their tasks. This re-training was conducted by trainers from the MoH with the support of the CS project.

Trainers started by evaluating TBA supervisions results from the previous year. TBAs supervisors are expected to conduct one supervision visit per month for each TBA. A total of 864 supervision visits were expected for the 72 TBAs corresponding to 12 supervision visits

per year and per TBA. It appeared that the percentage for the overall supervision of TBAs in the project area during 2003 was only 20.48% (177/864). In other words health centers agents conducted less than three supervision visits per TBA in 2003.

Additional topics covered during this re-training include the review of the national TBA curriculum, presentation and discussion about supervision tools, content of TBAs first aid kit and availability/replenishment of drugs and supplies at the health center level. Problems that TBAs listed include the fact that irregular supervision from health centers agents resulted in unavailability of supplies such as tetracycline, gloves, string for the ligature of the umbilical cord and sterilization products. Another problem was delays in payment of fee for services by the family. As mentioned above in B.3 the project organized a supervision meeting with the MoH to tackle the problems that the lack of supervision created and a solution was arrived at increasing the number of days of supervision from four to eight and reinforcing joint supervision between the MoH and the project.

C.3.2. Re-training of TBAs—This training took place from February 25 to March 3, 2004 for the first group of 34 trainees and from March 8-15, 2004 for the second group of 36 trainees. Seventy instead of seventy-two TBAs attended the training in the training room of the Siguiri prefectoral hospital. Two TBAs from the first group did not attend the training for family problems. It is unfortunate that the project was not able to provide them with a make up session. The TBAs were taught by trainers from the prefectoral hospital as well as nurses from health centers located in Siguiri center using the TBA training curriculum developed and approved by the MoH. Topics covered include anatomy/physiology of reproductive organs, prenatal care, TBAs first-aid kit contents and use, personal hygiene, emergency obstetric care, post natal care and importance of attending monthly meetings and report collection and writing. In addition, trainees had the opportunity of taking practical sessions on delivery, clean delivery technique and post natal care for the mother and her child at the maternity department of the prefectoral hospital in Siguiri. More specifically, the practical sessions for TBAs was about conducting deliveries under the supervision of hospital nurses in the maternity ward of the prefectoral hospital.

Methods used during this training include presentation, work group, demonstrations, role-playing, plenary session discussions and practical sessions. At the end of the training, trainees extended their gratitude to the CS project and to the MoH staff and expressed the wish that a second TBA be trained per village and that the project provides them with uniforms. The CS project did not have a budget to organize a training for a second TBA per village.

Pre and post tests were not conducted for this re-training as they are not mandatory in the national TBA training curriculum. However, the project does see relevance in doing pre and post tests to assess knowledge retention. The time spent between the training and the subsequent retraining was two years and six months as the first training was conducted in August and September, 2002.

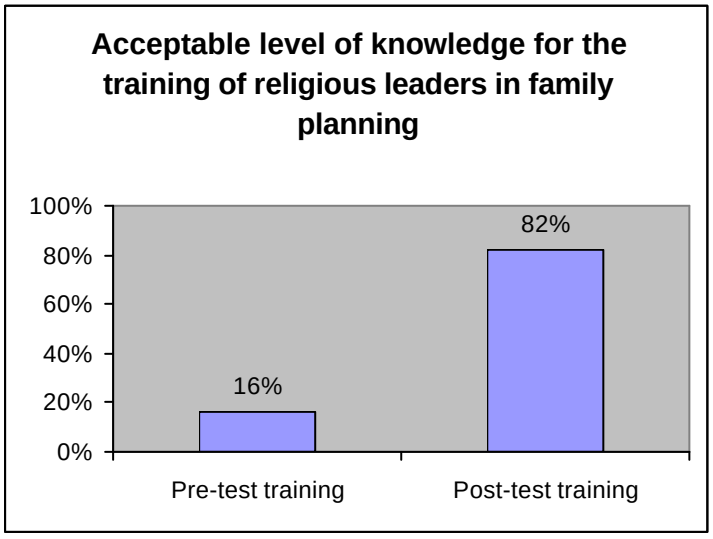
**C.4. Family planning**

During the reporting year, the CS project trained Muslim religious leaders, health volunteers (HVTs) and MoH health center staff in family planning. Family planning (FP) activities were not initially included in the project proposal. In April 2001 this intervention was included in project activities using funding provided by the NGOs Networks Program. The Child Survival project was fortunate to obtain additional funding to continue and support FP activities for the reporting year and through the end of the project through the Flex Fund.

C.4.1. Training of religious leaders—During the course of FY 2004, the project noticed that a respected Imam in the region of Kankan developed and was promoting an audio cassette with messages discouraging people from using family planning services and products. Because of the influence of that Imam the cassette was widely distributed in Kankan and surrounding areas that include the area covered by the project. The project reacted by contacting the regional Islamic league in order to identify appropriate actions to counteract the wrong messages spread out by the audio tape (Annex D). The project agreed with the regional Islamic league that a formal training of Imams was necessary for a better diffusion of appropriate messages. Training of Imams was also the best way of targeting a large audience using credible leaders. The Imams were expected to use the network of mosques to promote FP messages.

During the first quarter of FY 2004, the project trained 216 (3 per village) Moslem religious leaders in FP in the six sub-prefectures of the project area. The training was conducted in December 10-13, 2003 (Niagassola); December 14-17 (Doko); December 23-26 (Franwalia); December 27-30 ( Kintinian); January 01-04 (Commune urbaine) and January 05-08 ( Norassoba). The goal of the FP training was to: disseminate proper FP messages among religious leaders to ensure that they understand the importance of child spacing for the health of mothers and their children. Topics covered included: Islam and child health; Islam and the health of women; Islam and the well being of couples and Islam and family planning. Trainers were from the Regional Islamic League. The curriculum used for this training was developed by the Ulemas (Imams and other Islamic scientists ) of Guinea in collaboration with the CS project. The curriculum was developed by Ulemas through identifying appropriate passages in the Koran that recommend good health for the mother and their children which could therefore include child spacing.. To assess the acceptable level of knowledge, pre and post-test training were conducted and showed that 16% at pre and 82% at post-test had at least 60% of knowledge in FP and Islam. (See Annex E for the questionnaire)

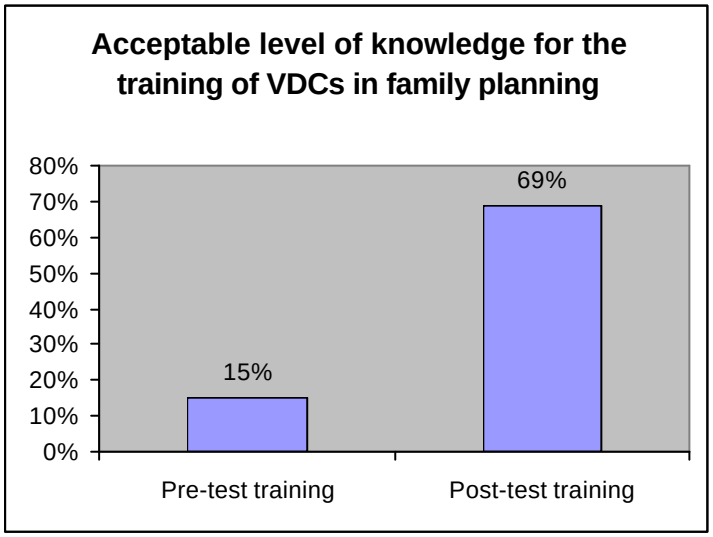
Graph 3: Results of pre and post-tests of the training of religious leader in family planning



C.4.2. Training of village development committees (VDC) members—Training of VDCs members in FP was for presidents and vice-presidents of VDCs and took place from April 20-28, 2004 with the collaboration of MoH prefectoral authorities. One hundred forty-three (two per district) VDCs attended the training. The training aimed at transferring follow up of FP activities to health volunteers in their respective communities. Topics covered included: job description of a health volunteer; meaning and advantages of family planning; pregnancy at risk; contraceptive methods; FP products which are available at the health volunteers ( HVTs) level and those requiring referral to a health professional; Islam and family planning. Trainers were from health centers and the CS project. Pre and post training test showed that 15% at pre and 69% at post had at least 60% of ALK.

The project noted that strong support of presidents and vice-presidents was necessary for successful implementation of FP activities. VDCs were trained in FP in order to provide them with understanding of FP goals that will enable them to provide adequate support to community agents and TBAs in their respective communities

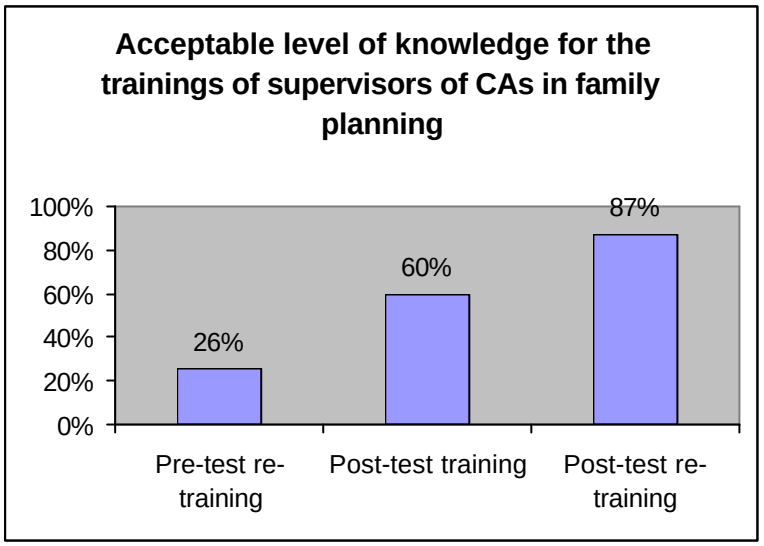
Graph 4: Results of pre and post-test training of VDCs in family planning




C.4.3. Re-training of supervisors of community agents—Re-training of supervisors of community agents (CA) took place from March 29 to April 9, 2004. Thirty trainees participated in the training that included head of health centers (8), prenatal care agents (7), EPI agents (8) and head of health posts (7) working in the project area. All community agents' supervisors in the project area attended the re-training. The re-training aimed at providing supervisors of CAs with refresher training on family planning as well as techniques for planning and implementing supervision activities. Topics covered included FP/STI/AIDS, information system, new supervisions techniques and community mobilization. Trainers were from the prefectoral directorate for health and from the CS project. Pre and post re-training test showed that 26% at pre and 87% at post had at least 75% of ALK.

In term of retention level between training and re-training, post tests for ALK shifted from 60% to 87%.

Graph 5: Results of pre and post-test re-training of supervisors of CAs in family planning




C.4.5. Re-training of community agents (CA)—The training of community agents (CA) in FP took place from May 1-18, 2004 in three districts that serve as training centers for the whole project area. Sixty-nine instead of 72 community agents attended the training sessions. Three CAs did not attend the training due to family problems or illnesses. The project organized a make up session for them from May 20-23, 2004. The goal of the training was to strengthen capacities of community agents in implementation and management of FP activities. Topics covered included anatomy/physiology of female and male reproductive organs; importance of FP; contraceptives methods; follow up of FP clients; home visits techniques; evaluation of religious leader activities and monthly meetings. Trainers were from the CS project. Pre and post re-training test showed that 40% at pre and 93% at post had at least 80% of ALK. Pre test results between training and re-training of community agents shifted from 18% in the initial training to 40%. Post test results between training and re-training of community agents shifted from 68% in the initial training to 93%.

Graph 6: Results of pre and post-test trainings of CAs in family planning

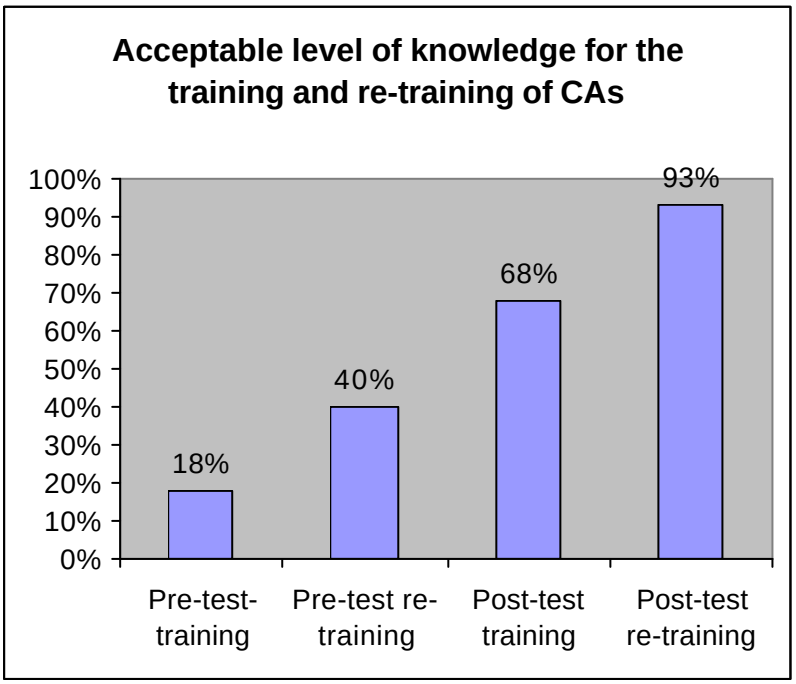


**Table 1: Summary Table of Trainings Organized from October 2003 to September 2004**

| No | Training topics | | Period | Duration | ALK | | # of participants | Professional affiliation |
|---|---|---|---|---|---|---|---|---|
| | | | | | Pretest | Posttest | | |
| 1 | Nutrition | | June 7-9,2004 | 3 days | 41% | 84% | 32 | -Head of health posts<br>-Vaccination agents of health centers |
| 2 | Immunization | | June 7-9,2004 | 3 days | 41% | 84% | 32 | -Head of health posts<br>-Vaccination agents of health centers |
| 3 | Safe motherhood | Re-training of TBAs supervisors | Feb 23-24, 2004 | 2 days | None | None | 15 | Health agents of health centers |
| | | Refresher training of TBAs | Feb 25 to March 03, 2004 | 8 days | None | None | 34 | TBAs |
| | | Re-training of TBAs | March 08-15, 2004 | 8 days | None | None | 36 | TBAs |
| 4 | Family planning | Training of religious leaders | Dec 10-Jan 8,2004 | 4 days per district | 16 | 82 | 216 | Imams and associate Imams |
| | | Training of village development committees members | April 20-28, 2004 | 7 | 15 | 69 | 143 | Presidents and vice-presidents of VDCs |
| | | Re-training of supervisors of community agents | March 29-April 9,2004 | 7 | 26 | 87 | 30 | Health agents of health centers |
| | | Re-training of community agents (CA) | April 1-18.2004 | 12 | 40 | 93 | 69 | Community agents |

## D. Field Activities

### D.1. Behavior Change Communication (BCC)

The goal of the BCC in ADRA's CS project is to introduce health messages to an audience as wide as possible. The estimated target beneficiary for BCC activities is 65892 (ADRA census, September 2003.). Key messages for all project interventions were delivered by field animators and health volunteers. Field animators and VDCs members held 4146 BCC sessions covering all interventions health messages per scheduled sessions targeting 38896 participants including 64% women and 36% men. BCC activities include home visits and health promotion sessions at the community level. Home visits are organized in houses that field animators have identified with specific health problems. A visit is then scheduled by the animator with the consent of the family and health messages focusing on the problems previously identified are transmitted in a face to face manner. Discussion and questions follow the presentation of the animator and are helpful in improving the understanding of the family.

Health promotion sessions at the community level are planned by the animators who identify the subject, the target population and the place. This identification process is based on the magnitude of health problems faced by various communities. Animators themselves or community agents use their megaphones to inform the community about the subject, the place and the target population. Presentation included causes and methods of prevention of the identified health problem as well as questions and discussions.

### D.2. Nutrition

Monthly growth monitoring of children 0-3 years old is the main activity conducted by the CS project in the area of nutrition. Approximately 47% of children 0-3 participated in growth monitoring in 72 villages during the reporting period. Among the children weighed, 84% (3139/3744) were well nourished (according to their weight for age), 14% (526/3744) moderately malnourished and 2% (79/3744) severely malnourished. The objective for moderate malnutrition was to reduce moderate malnutrition from 23% to 11%. Data at the end of September 2004 showed that moderate malnutrition is estimated at 14%.

Overall, the project has significantly contributed to the reduction of malnutrition. However, because of the low community mobilization in *Kintinian* and "*commune urbaine*" it has not been possible to reach the stated objective. The project objective for growth monitoring (GM) was to have 50% of children 0-3 years old monitored monthly for nutritional status. The CS project has identified that although the stated objective of 50% has not been attained during this reporting year there are some probable reasons that have contributed to this. Reasons for the low community mobilization in *Kintinian* include the high turn over of VDCs members. A gold mining company known as *'Societe Ashanti Goldfield" (SAG)* is located in the sub-prefecture of Kintinian. VDCs in the area of Kintinian have been changing regularly because of the preference for a paid job. The high turn over of VDCs members has affected community mobilization.

Reasons for low community mobilization in C*ommune urbaine* include the fact that Siguiri is a mining area. People go from villages located in the sub-prefecture of *Commune urbaine* to *Kintinian* and *Doko* Their constant migration to the mining zone for a few weeks makes

community mobilization for health activities difficult. Taking this mobile community into consideration ADRA has met with the DPS and VDCs and discussed about possible solutions. It was agreed to do growth monitoring on "holy days" when families are at home. Unfortunately this strategy has not significantly increased community mobilization in *Commune urbaine*. Another reason for the low community mobilization in *Commune urbaine* is that the animator who is in charge of *Commune urbaine* got a four months maternity leave. Her replacement by another animator was not properly organized and resulted in low quality field supervision.

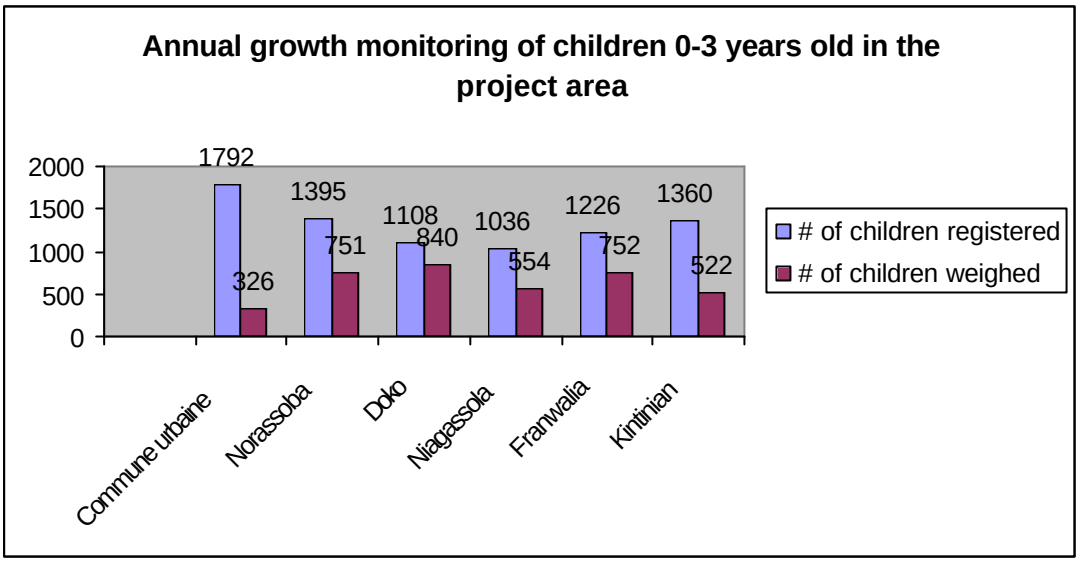
Unlike moderate malnutrition, severe malnutrition has been considerably reduced and is estimated at 2% at the end of September 2004. The overall project objective of reducing severe malnutrition from 20% to 10% has been fully achieved.

What happens to those that are in each color zone? Mothers with well nourished (green color) children are encouraged and advised to maintain their current nutritional habits. Mothers with moderately malnourished children (yellow color) are sent to the Positive Deviant Mother who provides them with advises in nutrition and does cooking demonstration using locally available foods. Severely malnourished children (red color) are referred to a health centers for treatment and care.

Table 2: Annual growth monitoring status of children in six sub-prefectures (i.e. 72 villages)

| **Sub-prefectures** | **# of children registered** | **# of children weighed** | **% of children weighed** | **Color** | | | | **%** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Green | Yellow | Red | Total | Green | Yellow | Red | Total |
| **Commune urbaine** | 1792 | 326 | 18 | 262 | 53 | 10 | 326 | 80 | 16 | 3 | 100 |
| **Norassoba** | 1395 | 751 | 54 | 684 | 52 | 14 | 751 | 91 | 7 | 2 | 100 |
| **Doko** | 1108 | 840 | 76 | 707 | 112 | 21 | 840 | 84 | 13 | 3 | 100 |
| **Niagassola** | 1036 | 554 | 54 | 439 | 103 | 12 | 554 | 79 | 19 | 2 | 100 |
| **Franwalia** | 1226 | 752 | 61 | 606 | 129 | 17 | 752 | 81 | 17 | 2 | 100 |
| **Kintinian** | 1360 | 522 | 38 | 441 | 76 | 5 | 522 | 84 | 15 | 1 | 100 |
| **Total** | 7917 | 3744 | 47 | 3139 | 526 | 79 | 3744 | 84 | 14 | 2 | 100 |

Graph 7: Annual GM of children 0-3 years in FY 2004




Another important nutritional activity that the project conducted during the reporting year is the follow up of children recruited for the third Hearth cycle and the implementation of the 4th cycle of Hearth sessions in twelve districts. Interesting findings from the follow-up of the 3rd cycle include the following:

- 83 children out of 169 (49%) moved from moderate malnutrition to a well nourished nutritional status after four months of follow up.

- 86 children out of 169 (51%) gained weight but were still moderately malnourished after four months of follow up.

A total of 12 Positive Deviant Mothers (PDM) were identified and trained prior to the 4th cycle Hearth session and served as trainer of other mothers during the Hearth session. The index weight for age was used to access the nutritional status of children after 12 days and after 2 months of follow up. PDM were selected based on the good nutritional/vaccination status of their children as well as their knowledge of hygiene practices as revealed by home visits of project field animators.

Twelve different Hearth sessions took place. ADRA did not provide supplemental food during these Hearth sessions and the mothers contributed by bringing locally available foods from home.

A total of 118 children were identified during GM activities and recruited for the 4th cycle of Hearth sessions but 12 dropped out before the end of the cycle. Nine children withdrew due to the choice of the mother despite the sensitization about the importance of completing the 12 days. Three children died of malaria. At the end of the 12 days (that include a day off on the seventh day) of Hearth sessions, the average weight gain per child and per village was generally between 200g and 500g or more which is in line with the WHO standard recommended range weight gain indicator (200g to 400g).

Difficulties encountered during the implementation of Hearth sessions include: dropping out of children, unavailability of local ingredients and illness of children. One of the weaknesses

of the 4th cycle was the failure in preventing drop outs. Despite unavailability of local ingredients, mothers were encouraged to find them for the well being of their children. Children who are sick during Hearth sessions are sent to health centers. Results of the weight gain in 12 days hearth sessions and 2 months of follow up are shown in the table below

**Table 3: Results of the 12 day and 2 months of hearth**

| Sub-prefectures | Sites | Average weight(g) per child in Day 1 | Average weight(g) per child in Day 12 | Average weight(g) gain per child in 12 days | Average weight(g) per child in Month 2 | Average weight(g) gain per child in 2 months |
|---|---|---|---|---|---|---|
| **Commune urbaine** | Niandankoura | 7445 | 7627 | 182 | 7622 | 177 |
| | Tiguibery | 7610 | 7990 | 380 | 8472 | 862 |
| **Norassoba** | Tassiliman | 7350 | 7700 | 350 | 8350 | 1000 |
| | Kossokokungbe | 7860 | 8170 | 310 | 8630 | 770 |
| **Doko** | Alahine | 8000 | 8529 | 528 | 9917 | 1917 |
| | Oudoula | 6983 | 7250 | 267 | 7440 | 457 |
| **Niagassola** | Dialawassa | 8100 | 8470 | 370 | 8870 | 770 |
| | Kiniekourou | 9550 | 9863 | 313 | 10533 | 983 |
| **Kintinian** | Didi | 7600 | 8167 | 567 | 8689 | 1089 |
| | Mankitin | 7670 | 8167 | 645 | 8100 | 430 |
| **Franwalia** | Bendougou | 8820 | 9100 | 280 | 9570 | 750 |
| | Diambaya | 8517 | 8975 | 458 | 9550 | 1033 |

Results at the end of the 2 months of hearth follow up, showed that of the 106 children weighed:

- 57(54%) gained more than 700g,

- 32 (30%) between 200g-699g

-17 (16%) less than 200g

## D. 3. Immunization

Field activities during the reporting year for immunization include collaboration with the MoH during national immunization days (NIDs) participation in outreach location activities and implementation of make up activities.

D.3.1 National Immunization Days

During NIDs that focused on tetanus toxoid (TT) for pregnant women, the project provided logistical support including vehicle and fuel to the Ministry of Health for the transportation of health center agents from their respective offices to the community

D.3.2 Participation in outreach location activities

The project staff participated in community mobilization, transportation of vaccines from the DPS to health centers and from health centers to outreach locations. Additional vaccines must be conveyed in health centers during NIDs because the stock available in health centers can not meet the increasing needs of these specific days. The project staff also contributed in writing the final report for NIDs in the Siguiri prefecture.

The project advocated to the Ministry of Health that efforts should be done to increase outreach vaccinations activities in general and that special attention should be given to mining zones. The MoH was committed to organize mobile teams that will provide vaccination on Fridays as there are no mining activities on Fridays. However only 44% (95/216) of outreach vaccinations activities planned were accomplished during FY 2004.

D.3.3 Implementation of make up activities

Project field animators continued to mobilize communities in the project area for outreach visits of health centers staff. Field animators also continued to work with health centers to organize make up sessions for areas showing low coverage rates for immunization. In other words, make up sessions referred to outreach vaccination activities which were organized to close the gap between the expected coverage and the real achievements in the field. The implementation of make up activities for immunization was done by project field animators who moved out to the community and were in contact with VDCs and community leaders in order to sensitize them on the importance of vaccination as well as informing them about the date, the hour, the place and the target population.
Data collected from VDCs community vaccination registers showed that with 66% of children 0-11 months who received oral poliomyelitis vaccine ,BCG, DPT 1-3 and measles and 75% of women of reproductive age who received at least two doses of tetanus toxoid, the project has achieved its objectives, which were 50% for the children and 70% for women .

## D.4. Safe motherhood

The project strategy for safe motherhood focused on capacity building of communities, MoH staff and implementation of social health insurance schemes for emergency obstetric care (MURIGA).

D.4.1 Capacity Building

Capacity building of communities and MoH staff in the area of safe motherhood refers to the development of the ability of communities and MoH staff to meet the health needs of pregnant women which include prenatal care, safe delivery and emergency obstetric care. As mentioned above in II.C.3, the CS project organized the re-training of supervisors of TBAs (MoH staff) and TBAs themselves during FY 2004.

D.4.2 Social Health Insurance Schemes (MURIGA or *Mutuelle*)

During the reporting year the project has completed the installation of MURIGA in all 72 districts. In all, 9,907 WRA are currently registered in the social health insurance program, comprising of 73% of women of reproductive age in targeted communities. After the successful establishment of the MURIGAs, ADRA obtained funding to strengthening social health insurances that are functioning in the project area. These funds were made available by PPSG (Projet Population Sante Genesique), a World Bank funded project in Guinea which agreed to sponsor all MURIGAs for 75% of their total contribution which is GNF 15,537,850. Therefore, the total amount donated was GNF 11,542,387 (about US$4,615). Money was given by issuing a check in a public œremony attended by ADRA country office officials, the CS project director and representatives of PPSG in June 1, 2004. This amount was proportionally distributed to all MURIGA based on the total amount contributed by MURIGA members. This donation boosted members' contribution from 11% at the end of the third quarter to 28% (2774/9907) at the end of the FY 2004.

Members of social health insurance schemes contributed an amount that varied between GNF 100 and GNF 500 every month. VDCs are responsible for collecting member's contribution for the social health insurance schemes. A cashier was chosen by community's members to keep the money. Double checking is ensured by VDCs members and CS field animators. In term of sustainability, an important activity was the setting of six coordinating committees for MURIGAs at the sub-prefecture level. These coordinating committees are composed of community members and administrative authorities from the sub-prefecture. The role of these coordinating committees is to supervise MURIGAs activities and to serve as a link between community members and the local administration as far as MURIGAs are concerned.

The project facilitated an agreement between MURIGAs and the hospital on one hand and on the other hand the union of drivers and the hospital in order to ease the transportation of women needing emergency obstetric care to the hospital. During FY 2004, 65/9907 women used MURIGA's services. References were done by health centers agents or TBAs. When a woman arrives at the hospital, a person accompanying her provides evidence of membership and contribution to MURIGA and service delivery is done without requesting a penny. The hospital bills the concerned MURIGA and payment is *expected* to be done within seven days. Unfortunately, the payment system is confronted with delays of payment. To improve the payment system, the project has committed field animators and technical supervisors to work closely with VDCs in order to sensitize them on the importance of paying on time the fees for services rendered by the prefectoral hospital.

To be eligible for MURIGAs services, women are expected to contribute GNF100 to GNF 500 per month whereas a woman who does not use MURIGAs services will be paying GNF 18000 to GNF 40000 for transportation and emergency obstetric care. Contribution rate per month and per woman is determined by the community based on both the distance from the

village to the hospital and the financial means of the community. In the majority of cases husbands are paying for their spouses but in some cases women are paying for themselves.

What happens to women who have not contributed and who need emergency obstetric care? This category of women is provided with help from MURIGA services under the condition that the husband will reimburse the money spent for transportation and medical care. In these specific cases, it has been noted that when a woman's life is saved by MURIGA's services the husband and the family are so grateful to MURIGAs that they will agree to reimburse the money spent and to start paying their monthly contribution to MURIGAs.

D.4.3. Installation of TBAs in the community

The 70 TBAs that were enrolled for the re-training were given an official "installation" into their respective communities. The objective of this installation was to make sure that refresher trained TBAs and their new skills were recognized and accepted by their communities. This event gathered community leaders, health center staff, project staff and the community at large. The project took this opportunity to inform the community about the role and responsibilities of the TBA, her new skills, the fees linked to her services and the responsibility of the community**.** Materials given to TBAs include a bag, gloves, string for ligature of the umbilical, towels, vitamin A, soap, bleach, razor blades, ointment, two buckets and plastic apron. These materials were given free of charge to TBAs. Fifty percent of fee for services of TBAs are for the health centers which will use this income to re-supply TBAs.

At the end of September 2004, 80% of births were assisted by nurses from health posts/centers agents (qualified personnel) or trained TBAs. This exceeds the project objective of having 70% of all births assisted by qualified personnel or trained TBAs.

**D.5. Family Planning**

The main field activity for FP has been the transfer of knowledge gained by the 216 religious leaders to the community.

- 71% of religious leaders have informed their communities about the goal and the content of the training they attended.
- 79% of religious leaders have done at least one Friday sermon with FP messages
- 86% of religious leaders have organized community health education with family planning messages.

According to field animator reports, religious leaders are using other opportunities such as baptisms to pass on FP messages. Baptisms of children in the Islamic faith are done in parent's home during the week that follows a birth of a baby. This ceremony is led by an Imam and gathered many persons including family members and friends. Overall, 32 % of religious leaders have done the two recommended activities (sermons and community health education).

ADRA has also submitted a concept paper for the 2005 Global Health Council regarding the project's work with Imam's. ADRA has seen this as an opportunity to document one aspect of the project and provide information to others. See concept submission in Annex D.

The project distributed FP materials such as 44 boxes that should be used to keep FP products and various FP forms, 72 registration books to health volunteers for the registration and tracking of FP clients, 72 FP audio recorded tapes made by the CS project, 72 boxes of posters with family planning messages, and training guide manuals for religious leaders developed by the regional Islamic league. Products were distributed to health centers for the replenishment of CAs, including condoms and pills.

The project also organized community mobilization aimed at creating synergy of actions among various FP actors (such as religious leaders, VDCs, Community agents) in order to maximize the impact and satisfy increasing demand for FP services. This community mobilization led to identification of female FP community agents as a response to the request by FP users who expressed concerns about interacting with male FP agents. The project has a list of these female FP community agents and their training is scheduled for FY 2005.

**D.6. Malaria**

The main activity as far as malaria is concerned was about conducting BCC sessions on causes, prevention, mode of transmission and symptoms for malaria. BCC activities on malaria included home visits and community health education. Home visits were scheduled by the animator with the consent of the family and key messages focusing on how to prevent malaria and identification of symptoms were transmitted in a face to face manner.

Community health educations are conducted by field animators and VDCs members and involve identifying the community, the place and the date of the session aimed at generating awareness on mosquitoes' reservoirs, mode of transmission, prevention and symptoms of malaria.
A total of 909 BCC sessions targeting 7710 participants were conducted by field animators and VCDs members in the area of malaria 2004.

**D.7. Sustainability**

Sustainability from the perspective of ADRA Guinea child survival project is multi-facet. The first was/is identifying and assuring as much as possible that health behaviors have been understood and accepted and change has taken or is taking place among beneficiaries. Secondly, there was/is continued cooperation between the MoH, VDCs and other community groups and a sense of ownership has ensued as seen by the initiation and increase in child survival intervention activities by partners.

During the reporting year, the project continued to work to integrate project activities with the MoH. Actions taken include developing 12 joint action plans with MoH health centers every month, conducting joint supervision of TBAs and health centers staff per quarter and the implementation of at least two health activities by VDCs. The exercise for developing joint action plans with health centers was done by field animators and health centers staff. These action plans covered activities such as outreach vaccination sessions, make up sessions for vaccinations and supervision of field activities by health center staff.

Statistics showed that 11 animators out of 12 developed at least one joint action plan every month. Only one animator did not develop a joint action plan during the last quarter of FY 2004. The animator who did not develop an action plan during the fourth quarter took a maternity leave. Her replacement by another animator was not properly organized and resulted in low quality field supervision in *Commune urbaine*. It was planned that the project

will conduct quarterly joint field supervision with the top local MoH representative. Three out of four quarterly field supervision visits were conducted. The joint field supervision visit scheduled for January-March 2004 did not take place as the DPS and the project were unable to agree on specific dates from overloaded calendars of both sides.

Another activity scheduled for sustainability was to have village development committees plan and implement at least two health activities such as growth monitoring, BCC sessions and cost recovery for social health insurance contribution.

## E. Factors that have contributed to achieving these accomplishments

### E.1. Support of local and national government

Local MoH representatives at the prefecture level have shown their support by encouraging health center staff to work with project animators as well as community groups organized by ADRA's CS project. Mutual understanding prevails between the project and the prefectoral hospital administration and staff as illustrated by the involvement of hospital staff in refresher training of TBAs. The MoH national office, particularly the department for safe motherhood, acknowledges ADRA's experience and success in implementing *Mutuelles* and is planning to send a mission to conduct supervision of TBAs and learn from the CS experience in the creation and management of social health insurance schemes.

### E.2. Interest and support of the community

The involvement of community leaders and the community at large in the implementation of child survival health activities is a key contributing factor for the achievements of the project objectives. The strategy of community empowerment for health, particularly the organization of VDCs and Mutuelles has enabled the development of a sense of ownership of project activities among community members as shown by the increasing rate of contributing members. In most villages the ADRA CS project is perceived as a facilitating agent.

### E.3. Hard work of project staff

Commitment of project staff to the achievement of project objectives is one of the main factors contributing to project accomplishments. Team spirit and the fact that a vast majority of project workers have a good understanding of their roles and responsibilities have facilitated the work at the project level. The fact that field animators are almost all from their own home project area and are acquainted with the language and the culture of the population they serve has made it easy to conduct field activities in villages.

**Table 4: Progress toward each program objectives**

| | ( yes or no ) | |
|---|---|---|
| **Nutrition**<br>Objectives:<br>1. Reduce from 23% to 11% mode rate malnutrition for children < 24 months<br>2. Reduce from 20% to 10% severe malnutrition for children < 24 months<br>3. 75% of mothers of children suffering from malnutrition participate in the Hearth program<br>4. 50% of children <24 months are weighed and monitored monthly for nutritional status<br>5. Increase from 23 to 35%, infants 0-6 months who are being exclusively breastfed<br>6. Increase from 6% to 25% mothers who practice appropriate weaning behaviors for children 6-9 months. | NO | -GM objective to have 50% of children participating in GM sessions is not fully achieved. Results for this objective show that 47% of children have been monitored. Two sub-prefectures are having a very low community mobilization indicator because populations migrate to the mining area. Another reason for the low community mobilization in *commune urbaine* is that the animator who is in charge of *commune urbaine* got a four months maternity leave. Her replacement by another animator was not properly organized and resulted in low quality field supervision<br>- Objective for moderate malnutrition was to reduce MM up to11% is **not fully achieved**. Results show a figure of 14% for MM.<br>- Objective for severe malnutrition was to reduce SM up to 10%. Results show a figure of 2%. **Fully achieved.** |
| **Vaccination**<br>Objectives:<br>1- Increase from 17% to 50% the number of children completely immunized before the age of 12 months<br>2- Increase from 38% to 70% women of reproductive age who have received at least two doses of TT | YES | -Objective was to have 50% of children completely vaccinated by age 12 months. Current 66%.**Fully achieved**.<br>-Objective was to have 70% of WRA who received at least 2 doses of TT.Current is 75%.**Fully achieved.** |
| **Safe motherhood**<br>Objectives:<br>1- Increase from 41% to 65% mothers with children < 24 months who had at least 3 prenatal consultations before the birth of their child.<br>2- Increase from 5% to 30% mothers with children < 24 months who know at least two danger signs of pregnancy<br>3- Increase from 1% to 30 % mothers with children < 24 months who know at least 2 signs of danger in delivery<br>4- Increase from 48% to 70%, mothers with children <24 months who were assisted by qualified health personnel during their last delivery.<br>5- Increase from 15% to 40% mothers with children under 2 who were advised to immediately breastfeed their child upon delivery<br>6- 40% of the districts have established and organized mutuelles for managing EOC | YES | 100% (72/72) of districts have established and organized mutuelles. The objective was 40% **Fully achieved.**<br>80% of births are assisted by TBAS and health centers/health posts agents The objective was 70%. **Fully achieved.** |
| **Family planning**<br>Family planning was not initially included in the project proposal. Therefore core FP indicators were not included in the baseline. | YES | FP was not initially included in the project proposal. .It was added later through NGOs Networks and now with the Flex Fund support.<br>The aim of the flex fund support |

## III. Factors impeding progress

### A. Geographic

The main geographic constraint that ADRA CS project is facing is the isolation of the project from the country office in Conakry. The project is located almost 800 km from Conakry and requires about 12 hours travel. Therefore there had been delays in cash transactions, which affect project activities. The road network within the project area is very poor. Many areas are without access during the rainy season. This affects the quality of field supervision. Weather conditions in Siguiri are very harsh especially during the dry season (March-May).

### A.1. Actions taken to overcome geographical constraints

To overcome the long distance between the country office and Siguiri, the project has established regular taxi-mail transportation through road transport services. In effect, the project signed a contract with a bus driver who is then committed to take projects mails to Conakry and from Conakry to Siguiri twice a week.

In spite of the inaccessibility of villages such as Sougoula and Kiniebakoro in Commune urbaine as well as Landy, Gbenkorokoro and Norakoro in the sub-prefecture of Norassoba during the rainy season, the project has continued to work in these areas by crossing the river in canoes. Villages such as Niandankoura and Tassiliman respectively in the sub-prefecture of Commune urbaine and Norassoba are completely inaccessible due to the water flood during the rainy season. Canoes are not available. Therefore the project does not work in these specific villages for four weeks or more.

### B. Communication

The distance between the project site and country office makes it difficult to have regular communication. Telecommunication services are not reliable and function occasionally. Land telephone lines and the internet do not exist. Fortunately mobile telephones lines are now available but the mobile telephone network is not reliable nationally and the area of Siguiri is not yet properly covered by the mobile telephone network.

### B.1. Actions taken to overcome communication constraints

Although the mobile telephone network does not function properly in Siguiri, mobile phones are used by the project for communication purposes with ADRA country office in Conakry. Because the number of available mobile telephone lines (SIM cards) is short at the country level, ADRA successfully advocated to the national telephone company to avail cell phones to the project in Siguiri. In addition, the satellite phone/email connection of the ADRA's food security project in Siguiri is sometime used by the CS project to overcome communication constraints.

### C. Technical constraints

The technical challenge that the project faces is related to mobilizing communities for health activities in mining areas. As previously mentioned the population in mining zones is in

constant transition depending on mining activities and spends most of their time in the mines. The quest for gold is a long-standing activity in Siguiri and community mobilization has been a constant challenge for the project in this area.

### C.1 Actions taken to overcome the technical constraints

To overcome this constraint, the project planned to approach these communities on Fridays when they do not work in mines. The project in collaboration with the MoH organized a special team to intervene in mining areas in addition to the regular health team in the zones. The special team was assigned the responsibility to implement outreach vaccinations in mining zones. Unfortunately, this strategy has not generated increasing interest in health related activities from mining communities and is in discussion with the DPS and communities to identify other suggestions.

## D. Economical constraints

Poverty is certainly the main economic constraint in the CS project area. Many families are living below the poverty line. The quest for income to meet daily needs leads beneficiary populations to search for employment in the mining sector. This has obviously created a pocket of the population that is at higher risk of limited knowledge about good health behaviors due to their constant mobility.

### D.1 Actions taken to overcome the economical constraints

The project did not take specific actions to fight against poverty in the project area. Nevertheless, the project advocated to the MoH to take into account the constant mobility of population to/from the mines as mentioned above in II.D.3.2 and III.C.1.

## IV. Technical assistance needed

Technical assistance is needed in the areas of monitoring and evaluation, lot quality assurance sampling training (LQAS) and management of a network of social health insurances schemes in rural areas.

A. Monitoring system

During FY 2005 the ADRA-GUINEA country director, Dr Sharon Pittman and the new project director will work together with the monitoring and evaluation coordinator to assess the current mechanisms for gathering information as well as identifying ways for improving data management system and quality of data collected. However, being that the project will be closing in September 2005, this technical assistance will be extremely beneficial in the integration of health into ADRA's Title II program.

B- Lot Quality Assurance Sampling (LQAS)

The CS project needs technical assistance in lot quality assurance sampling. Training in this rapid survey method will enable the project through technical supervisors to assess the coverage of key maternal and child health knowledge and practices as well as the quality of health workers performances. However, being that the project will be closing in September 2005, this technical assistance will be more beneficial in the integration of health into ADRA's Title II program.

C- Management of a network of MURIGAs

Another area that needs technical assistance is the management of a network of social insurance schemes (MURIGAs) that the project created in 72 villages. The project would like to learn from experts or from other NGOs experiences the best management practices for the sustainability of *mutuelles*. ADRA would like to expand this network in the new integration project. ADRA plans to document lessons learned in the MURIGA

## V. Program changes

### A- Staff changes

Staff changes occurred at the level of the administration of ADRA/Guinea in the main Conakry office and at the project level.
Mrs. Sharon Pittman, PhD was appointed country director for ADRA/Guinea during the reporting year and Mr. Max Langi was recruited in the position of director of finances in 2004. The country office organigram was revised in such a way that the previous acting country director, Mr. Stephen Amoako was assigned the responsibility of Programs director. These positions, although not key staff of the project are in administration of ADRA/Guinea in country office. At the level of the project, Mr. Jean Pythagore Biyik, MPH was recruited to serve as the CS project director starting September 20, 2004 following the end of the contract of Mrs. Elisabeth Kibour.

**B- DIP changes**

The census revealed the actual population size of ADRA's CS to be 64,097 as opposed to the 167,000 mentioned in the DIP. Children 0-11 which represent 4% of total population are estimated at 2,564; children 0-3 years (7,917) and women of reproductive age (WRA) are 12,819 (25%). Projects results will be calculated using these figures.

**C- Mid-term evaluation changes**

The chart below provides information regarding issues or recommendations raised in the midterm evaluation. For each issue or recommendation raised ADRA is providing information of how the program is addressing the issue or recommendation.

Table 5: Approaches for addressing recommendations/issues raised by the mid-term evaluate

| **Mid-term evaluation issues or recommendation** | **Approach for addressing the issues or recommendation** |
|---|---|
| Increase immunization coverage in isolated areas | The project advocated to the MoH that efforts should be done to conduct immunization activities in isolated areas. The project worked with the MoH to conduct vaccination on Fridays in mining zones. But only 44% (95/216) of outreach vaccination activities were conducted. |
| Advocate at the MoH level to address the shortage of contraceptives | The project bought and donated an initial stock of contraceptives to the MoH health centers in April 2004. This initial stock was to provide health volunteers with FP products that they can sell before coming back to the HC to replenish their stock. This was a beginning and advocacy with MoH continues. |
| Provide more training for malaria | The number of BCC sessions on malaria has decreased from 963 in FY 2003 to 909 in FY 2004. We will be addressing this seriously in the next year. |
| Re-training for TBAs | The project provided refresher training to 72 TBAs, and 15 supervisors of TBAs. |
| Work with the regional Islamic league to disseminate family planning message | The projects developed a workplan with the regional Islamic league, trained 216 religious leaders in FP, distributed 72 audio tapes with FP messages and monitored activities of Islamic leaders in the field. |
| Adopt the September 2002 survey of PRISM to serve as a baseline survey for FP | This recommendation will be integrated for follow-on activities October 2004 to September 2005 |
| Strengthen the link between VDCs and PADRAS for the fight against poverty | ADRA is currently in the process of integrating health activities, food security and |

| | |
|---|---|
| | micro-credit into a single integrated project in the area of Siguiri. |
| Advocate at the DPS level to address the shortage of vaccines | Advocacy for availability of vaccines was done at the DPS level. But shortages of vaccines (BCG,DT, and Polio) was still observed in certain areas |
| Provide training to VDCs members in basic management methods | Not achieved in FY 2004. Training of VDCs members in basic management method is planned for follow on activities in December 2004. |
| Provide health centers and health posts in isolated areas with cold chains | The project did not get funding to provide health centers/posts with cold chains during FY 2004. However, ADRA donated 11 cold chains from world bank funding to selected health centers/posts in August 2002. This topic is under continual discussion with the DPS. |
| Avails opportunity for the HIS coordinator to get training in ACCESS database | The HIS coordinator had a one week training in ACCESS in August 2003. Trainers were from STATVIEW, a Conakry based survey and research consulting office. |

## VI. Management systems

### A- Financial management system

Drawdown

ADRA Guinea is a sub recipient of ADRA HQ and therefore drawdowns are requested by the ADRA HQ finance department against an ADRA letter of credit. These drawdowns are initiated in response to a request by the field. The decision to approve a drawdown is made based on the financial reports provided by the finance department of ADRA Guinea,

Accounting

At the field level the working budget is the base of the chart of accounts in the computer program that is used to track expenditures. The program maintains balance in USD and can produce reports in both GNF and USD currencies based on an established exchange rate that is adjusted monthly based on Guinea central bank publishing. The accounting program provides project administration with financial statements comparing total expenses with budgeted amounts. This system allows monthly budget monitoring and helps the finance department to follow the expenditure plan made in the DIP.

Petty cash

The daily administration of ADRA Guinea's finance frequently requires the payment of small amounts for minor expenses. The most efficient manner of caring for this type of payment is through the establishment of a petty cash system. Therefore a petty cash system is in use. Presently there is one petty cash in Conakry for GNF500 000 about US$189 and another one

in Siguiri for GNF 3 500 000 about US$ 1320. The petty cash replenishment is done with a check from the bank, based upon the documented expenditures made to that point.

Bank accounts

The project maintains three bank accounts to be able to operate the project smoothly. There is one local currency account that is used for daily transactions. There are two bank accounts in US$ currency, one in Washington used to receive funds and to pay for US based expenses and another one in Conakry use to make transfers and change to local currency.

Checks are drawn up by the accountant and approved by the project manager and the finance director. Signatories to the checks are the finance director and project director, the country director and the chairman of the ADRA Guinea board of directors.

Financial reports

Monthly financial statements are sent to the ADRA HQ office. The expenditures are traced by the financial analyst who refers potential problems to the Senior Finance Administrator. This helps to avoid inappropriate use of funds and aids in tracking project activities

Financial Audit

ADRA Guinea is a participant in the overall institutional audit of ADRA international, mandated by Office of management and Budget (O M B) circular A- 133. The accounting firm of Price Waterhouse Coopers (PWC) conducts this audit annually. The scope of this audit includes all Federal projects for which ADRA international is a funding recipient. Examinations of implementing field offices are scheduled based on availability of qualified providers of audit services and other logistics consideration. Any material findings associated with the implementing of project in Guinea are reflected in the overall audit report provided by PWC to ADRA international. In that report, the field office associated with each finding is clearly identified. ADRA international works with those field offices and donor agencies to resolve all findings. There are presently no outstanding issues from audit findings.

**B. Human resources**

An organigram that defines all project positions including job descriptions is available (see Annex F). The main change that affected this organigram in term of staff turn over is the recruitment of a new project director, namely Jean Pythagore Biyik in September 2004.

ADRA CS project has a human resources system that performs staff evaluation on a yearly basis. Each staff member is evaluated by his direct supervisor using a standard evaluation form for all ADRA/Conakry employees. The staff evaluation is shared with employees in order to show them areas of good performances and areas that need improvement. All filled evaluation forms are reviewed by the project Director.

All ADRA/Guinea CS project national employees are eligible for 4 weeks of vacation and compensation that include reimbursement of medical expenses and payment of retirement fund at the government social security fund level.

Career development has been ensured by the hands on experience obtained in the field and various training provided to the staff which will enable them to easily find another job even if the project ends.

**C. Communication system and team development**

As mentioned above, cell phones are now available in Siguiri. Although, the mobile telephone network is not yet a reliable system, it remains the main mean of communication in case of emergency/disaster. Another mean of communication in the case of emergency/disaster include the radio system that connects the project and the country office in Conakry.

Currently, there is not a written plan for evacuation of ADRA's expatriate employees working in the area of Siguiri but is under development. ADRA places responsibility on expatriate employees or their national governments to take an active role in their own evacuation. However, a checklist that provides information about the most essential emergency supplies is given to ADRA expatriate workers in Siguiri at the beginning of the contract. ADRA country office is planning to provide expatriate employees with satellite phones that will enable them to easily get into contact with the country office and inform their family and friends at home that they are safe in the case of emergency/disaster.

ADRA has also submitted a concept paper for the 2005 Global Health Council regarding the project's work with Imam's. ADRA has seen this as an opportunity to document one aspect of the project and provide information to others. See concept submission in Annex D.

**D. Local partner relationships.**

In term of partnership, the child survival project participated at three regional meetings organized by the MoH that aimed at strengthening the links between health actors as well as improving coordination of health activities in the region of Kankan that include the project area . The project collaborated with *PRISM* an NGO working in Guinea with a reproductive health focus. Partnership with PRISM focused on positively responding to invitations from PRISM to participate in the launching of a regional campaign to fight HIV/AIDS and the implementation of STI/HIV/BCC sessions at the prefecture level in August 2004.

The project also contacted *Save the Children* to learn from their in-country experience on the management of a network of Mutuelles. The project's technical supervisor for MURIGAs spent 4 days to grasp *Save the Children/*Guinea experience in mutuelles.

Another important collaboration was with *PPSG (Projet Population Sante Genesique)*, a World Bank funded project that provided incentive funding for MURIGA *(Mutuelles pour les Risques liees a la Grossesse et a l'Accouchement*). PPSG is willing to grant funding to organizations implementing health insurances schemes throughout the country. It is based on this information that the project contacted PPSG in order to obtain funding for MURIGAs created by ADRA in its project area. See II.D.4.2 above for details about social health insurance schemes

**E. PVO coordination/collaboration in country**

ADRA CS in Guinea was contacted by Engender Health, as part of the ACQUIRE project to participate in a study aimed at investigating awareness of Intrauterine Device (IUD) among communities in Kankan, Mandiana and Siguiri. ADRA did not participate in this study as the letter inviting ADRA to the start up workshop regarding the IUD study arrived in ADRA's office in Siguiri on September 13, 2004 whereas the workshop was scheduled on September 9, 2004.

**F. Other relevant management system**

The Project meets regularly with the DPS and local partners to address any needed programmatic changes. With Jean Biyik coming on board as the project director, Dr Sharon Pittman the new country director will be spending extra time in Siguiri with project staff in the coming project year. Debbie Herold, of ADRA International HQ, will also be making a programmatic visit in December 2004.

**G. Timeline of activities for the coming year**

| **ACTIVITIES** | **COMPLETION DATES** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | O | N | D | J | F | M | A | M | J | J | A | S |
| WORKSHOP | | | | | | | | | | | | |
| Sustainability workshop | | X | | | | | | | | | | |
| TRAININGS | | | | | | | | | | | | |
| Training of 144 VDCs in basic management methods | | | X | | | | | | | | | |
| Training of 72 female CAs in family planning | | | | X | | | | | | | | |
| Post training installation of CAs | | | | | X | | | | | | | |
| Training of 72 CAs in usage of checklist for family planning | | | | | | | X | | | | | |
| BEHAVIOR CHANGE COMMUNICATION | | | | | | | | | | | | |
| Monthly BCC sessions | X | X | X | X | X | X | X | X | X | X | X | X |
| Special quarterly BCC sessions | | | X | | | X | | | X | | | X |
| Monthly diffusion of health messages on the rural radio | | | X | X | X | X | X | X | X | X | X | X |
| NUTRITION | | | | | | | | | | | | |
| Monthly growth monitoring of children 0-3 years old | X | X | X | X | X | X | X | X | X | X | X | X |
| Hearth sessions | | | X | | | X | | | | | | |
| IMMUNIZATION | | | | | | | | | | | | |
| Support of monthly outreach vaccinations activities | X | X | X | X | X | X | X | X | X | X | X | X |
| SAFE MOTHERHOOD | | | | | | | | | | | | |
| Monthly supervision of TBAs | X | X | X | X | X | X | X | X | X | X | X | X |
| Monthly supervision of social health insurance schemes | X | X | X | X | X | X | X | X | X | X | X | X |
| Meeting between hospital +union of drivers + CS Project regarding the functioning of social health insurance | | | X | | | X | | | X | | | |
| MONITORING | | | | | | | | | | | | |
| Monthly and quarterly joint supervision | X | X | X | X | X | X | X | X | X | X | X | X |
| Monthly and quarterly staff meeting | X | X | X | X | X | X | X | X | X | X | X | X |
| Monthly report of technical supervisors | X | X | X | X | X | X | X | X | X | X | X | X |
| Quarterly reports of project director | | | X | | | X | | | X | | | |
| EVALUATION | | | | | | | | | | | | |
| Closeout process | | | | | | | X | X | X | X | X | X |
| Final evaluation of the project | | | | | | | | X | X | | | |
| Financial audit | | | | | | | | X | X | | | |

**H. New methodology if any**

None

**ANNEXES**

**Annex A: Districts/villages covered by ADRA/CS**

| Sub-prefectures | Districts | Sub-prefectures | Districts |
|---|---|---|---|
| **COMMUNE URBAINE** | Falama | **NIAGASSOLA** | Balandougou |
| | Niandankoura | | Fidako |
| | Bambala | | Dialawassa |
| | Djilémgbè | | Sininko |
| | Kinièbakoro | | Kouyakouya |
| | Sougoula | | Fètèkou |
| | Sébékoro | | Kinièkourou |
| | Djatéla | | Farabalen |
| | Sambaya Kofilani | | Kèda |
| | Saourou | | Tondo |
| | Dankakoro | | Dora |
| | Tiguibiri | **FRANWALIA** | Bananinkoro |
| **NORASSOBA** | Tassilima | | Kamaya |
| | Fandia | | Diambaya |
| | Kossokoba | | Kofilani |
| | Dalanikan | | Sambaya |
| | Fragbèba | | Sobata |
| | Lemouroutombo | | Kossogna |
| | Norakoro | | Bougourou |
| | Gbènkorokoro | | Kotoma |
| | Landy | | Bendougou |
| | Kossokokoumgbè | | Koma |

| | | | |
|---|---|---|---|
| | Leleda | | Koudédi |
| | Todakoudounkan | **KINTINIAN** | Fèfè |
| **DOKO** | Kourémalé | | Didi |
| | Kodjarani | | Boukaria |
| | Kolita | | Balato |
| | Dalamban | | Doubaya |
| | Oudoula | | Diarraya |
| | Tomboni | | Alahinè |
| | Soumbarakoba | | Mankiti |
| | Alahinè | | Fifa |
| | Souloukouni | | Samani |
| | Tombogo | | Fatoya |
| | Bourenfè | | Kamatiguiya |
| | Kinièbakoura | | Tintisabani |

## Annex B: Results of census of project beneficiaries

| SUB-EFECTURES | Districts | POP 2004 | 4% | 4% | 12% | 6% | 4.50% | 10% PNC | 20% PNC | 2% PNC | 20% |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | EPI 0-11 MONTHS | POST-PARTUM VIT.A | GM 0-35 MONTHS | FAMILY PLANNING | PNC 15-49 YRS | REF OF PREGNANT WOMEN | ACCOUCH DYSTOCIQUE | C-SECTIONS | WRA |
| COMMUNE URBAINE | Falama | 1,903 | 76 | 76 | 228 | 114 | 86 | 9 | 17 | 2 | 38 |
| | Niandankoura | 812 | 32 | 32 | 97 | 49 | 37 | 4 | 7 | 1 | 16 |
| | Bambala | 694 | 28 | 28 | 83 | 42 | 31 | 3 | 6 | 1 | 13 |
| | Djilémgbè | 671 | 27 | 27 | 81 | 40 | 30 | 3 | 6 | 1 | 13 |
| | Kinièbakoro | 1,452 | 58 | 58 | 174 | 87 | 65 | 7 | 13 | 1 | 29 |
| | Sougoula | 977 | 39 | 39 | 117 | 59 | 44 | 4 | 9 | 1 | 19 |
| | Sébékoro | 508 | 20 | 20 | 61 | 30 | 23 | 2 | 5 | 0 | 10 |
| | Diatéla | 728 | 29 | 29 | 87 | 44 | 33 | 3 | 7 | 1 | 14 |
| | Sambaya kofilani | 469 | 19 | 19 | 56 | 28 | 21 | 2 | 4 | 0 | 9 |
| | Saourou | 966 | 39 | 39 | 116 | 58 | 43 | 4 | 9 | 1 | 19 |
| | Dankakoro | 1,142 | 46 | 46 | 137 | 69 | 51 | 5 | 10 | 1 | 22 |
| | Tiguibiry | 1,661 | 66 | 66 | 199 | 100 | 75 | 7 | 15 | 1 | 33 |
| | **Total** | 11,983 | **479** | **479** | **1,438** | **719** | **539** | **54** | **108** | **11** | **2,39** |
| NORASSOBA | Tassilima | 889 | 36 | 36 | 107 | 53 | 40 | 4 | 8 | 1 | 17 |
| | Fandia | 1,47 | 59 | 59 | 176 | 88 | 66 | 7 | 13 | 1 | 29 |
| | Kossoko | 234 | 9 | 9 | 28 | 14 | 11 | 1 | 2 | 0 | 4 |
| | Dalanikan | 370 | 15 | 15 | 44 | 22 | 17 | 2 | 3 | 0 | 7 |
| | Fragbèba | 253 | 10 | 10 | 30 | 15 | 11 | 1 | 2 | 0 | 5 |
| | Lemourou Tombo | 313 | 13 | 13 | 38 | 19 | 14 | 1 | 3 | 0 | 6 |
| | Norakoro | 1,137 | 45 | 45 | 136 | 68 | 51 | 5 | 10 | 1 | 22 |
| | Gbènkorokoro | 2,126 | 85 | 85 | 255 | 128 | 96 | 10 | 19 | 2 | 42 |
| | Landy | 369 | 15 | 15 | 44 | 22 | 17 | 2 | 3 | 0 | 7 |
| | Kossokokoungbè | 278 | 11 | 11 | 33 | 17 | 13 | 1 | 3 | 0 | 5 |
| | Leleda | 780 | 31 | 31 | 94 | 47 | 35 | 4 | 7 | 1 | 15 |
| | Todakoudounkan | 319 | 13 | 13 | 38 | 19 | 14 | 1 | 3 | 0 | 6 |
| | **Total** | 8,538 | **342** | **342** | **1,025** | **512** | **384** | **38** | **77** | **8** | **1,70** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Kourémalé | 1,684 | 67 | 67 | 202 | 101 | 76 | 8 | 15 | 2 | 33 |
| | Kodjarani | 1,042 | 42 | 42 | 125 | 63 | 47 | 5 | 9 | 1 | 20 |
| | Kolita | 762 | 30 | 30 | 91 | 46 | 34 | 3 | 7 | 1 | 15 |
| | Dalamban | 1,032 | 41 | 41 | 124 | 62 | 46 | 5 | 9 | 1 | 20 |
| | Oudoula | 958 | 38 | 38 | 115 | 57 | 43 | 4 | 9 | 1 | 19 |
| | Tomboni | 1,366 | 55 | 55 | 164 | 82 | 61 | 6 | 12 | 1 | 27 |
| **DOKO** | Soumbarakoba | 1,244 | 50 | 50 | 149 | 75 | 56 | 6 | 11 | 1 | 24 |
| | Alahinè | 685 | 27 | 27 | 82 | 41 | 31 | 3 | 6 | 1 | 13 |
| | Souloukouni | 787 | 31 | 31 | 94 | 47 | 35 | 4 | 7 | 1 | 15 |
| | Tombôgô | 861 | 34 | 34 | 103 | 52 | 39 | 4 | 8 | 1 | 17 |
| | Bourenfè | 288 | 12 | 12 | 35 | 17 | 13 | 1 | 3 | 0 | 5 |
| | Kinièbakoura | 2,358 | 94 | 94 | 283 | 141 | 106 | 11 | 21 | 2 | 47 |
| | **Total** | 13,067 | **523** | **523** | **1,568** | **784** | **588** | **59** | **118** | **12** | **2,61** |
| | Balandougou | 1,08 | 43 | 43 | 130 | 65 | 49 | 5 | 10 | 1 | 21 |
| | Fidako | 409 | 16 | 16 | 49 | 25 | 18 | 2 | 4 | 0 | 8 |
| | Dialawassa | 483 | 19 | 19 | 58 | 29 | 22 | 2 | 4 | 0 | 9 |
| | Siniko | 563 | 23 | 23 | 68 | 34 | 25 | 3 | 5 | 1 | 11 |
| | Kouyakouya | 420 | 17 | 17 | 50 | 25 | 19 | 2 | 4 | 0 | 8 |
| | Fètèkou | 498 | 20 | 20 | 60 | 30 | 22 | 2 | 4 | 0 | 10 |
| **IAGASSOLA** | Kignékourou | 517 | 21 | 21 | 62 | 31 | 23 | 2 | 5 | 0 | 10 |
| | Farabalen | 425 | 17 | 17 | 51 | 26 | 19 | 2 | 4 | 0 | 8 |
| | Kèda | 941 | 38 | 38 | 113 | 56 | 42 | 4 | 8 | 1 | 18 |
| | Tando | 997 | 40 | 40 | 120 | 60 | 45 | 4 | 9 | 1 | 19 |
| | Dora | 509 | 20 | 20 | 61 | 31 | 23 | 2 | 5 | 0 | 10 |
| | Bananinkoro | 271 | 11 | 11 | 33 | 16 | 12 | 1 | 2 | 0 | 5 |
| | **Total** | 7,113 | **285** | **285** | **854** | **427** | **320** | **32** | **64** | **6** | **1,42** |
| | Kamaya | 747 | 30 | 30 | 90 | 45 | 34 | 3 | 7 | 1 | 14 |
| | Diambaya | 635 | 25 | 25 | 76 | 38 | 29 | 3 | 6 | 1 | 12 |
| | Kofilani | 719 | 29 | 29 | 86 | 43 | 32 | 3 | 6 | 1 | 14 |
| | Sambaya | 1,792 | 72 | 72 | 215 | 108 | 81 | 8 | 16 | 2 | 35 |
| | Sobata | 315 | 13 | 13 | 38 | 19 | 14 | 1 | 3 | 0 | 6 |
| **'RANWALIA** | Kossogna | 499 | 20 | 20 | 60 | 30 | 22 | 2 | 4 | 0 | 10 |
| | Bougouroun | 1,96 | 78 | 78 | 235 | 118 | 88 | 9 | 18 | 2 | 39 |
| | Kotoma | 593 | 24 | 24 | 71 | 36 | 27 | 3 | 5 | 1 | 11 |
| | Bendougou | 853 | 34 | 34 | 102 | 51 | 38 | 4 | 8 | 1 | 17 |
| | Koma | 950 | 38 | 38 | 114 | 57 | 43 | 4 | 9 | 1 | 19 |
| | Koudédi | 360 | 14 | 14 | 43 | 22 | 16 | 2 | 3 | 0 | 7 |
| | Fèfè | 670 | 27 | 27 | 80 | 40 | 30 | 3 | 6 | 1 | 13 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Total** | 10,093 | **404** | **404** | **1,211** | **606** | **454** | **45** | **91** | **9** | **2,01** |
| | Didi | 856 | 34 | 34 | 103 | 51 | 39 | 4 | 8 | 1 | 17 |
| | Boukaria | 1,804 | 72 | 72 | 216 | 108 | 81 | 8 | 16 | 2 | 36 |
| | Balato | 4,037 | 161 | 161 | 484 | 242 | 182 | 18 | 36 | 4 | 80 |
| | Doubaya | 891 | 36 | 36 | 107 | 53 | 40 | 4 | 8 | 1 | 17 |
| | Diarraya | 814 | 33 | 33 | 98 | 49 | 37 | 4 | 7 | 1 | 16 |
| | Alahinè | 829 | 33 | 33 | 99 | 50 | 37 | 4 | 7 | 1 | 16 |
| **KINTINIAN** | Mankity | 1,353 | 54 | 54 | 162 | 81 | 61 | 6 | 12 | 1 | 27 |
| | Fifa | 513 | 21 | 21 | 62 | 31 | 23 | 2 | 5 | 0 | 10 |
| | Samani | 974 | 39 | 39 | 117 | 58 | 44 | 4 | 9 | 1 | 19 |
| | Fatoya | 1,286 | 51 | 51 | 154 | 77 | 58 | 6 | 12 | 1 | 25 |
| | kamatiguiya | 1,012 | 40 | 40 | 121 | 61 | 46 | 5 | 9 | 1 | 20 |
| | Tintissabani | 729 | 29 | 29 | 87 | 44 | 33 | 3 | 7 | 1 | 14 |
| | **Total** | **15,098** | **604** | **604** | **1,812** | **906** | **679** | **68** | **136** | **14** | **3,0** |
| | **Total Général** | **65,892** | **2,636** | **2,636** | **7,907** | **3,954** | **2,965** | **297** | **593** | **59** | **13,17** |

**Annex C: Action plan for improving field supervision**

| Activities | Completion dates | Expected results |
|---|---|---|
| 1- Problems identification<br><br>1-1- Joint meeting between the ministry of health and the CS project aimed at improving supervision | **October 2003** | 1 Reasons for low involvement of the MoH in supervision activities are identified<br>1- Decision to developed new data collection tools for social health insurances schemes is agreed.<br>2- Reasons for inadequate supervision from project's supervisors are identified. |
| 2- Point of interventions<br>1-1- Increase the participation of MoH staff in field supervision<br>1-2- Increase the time that project supervisors spend in the field from 4 to 8 days<br>1-3- Provide technical support to field animators and MoH staff | **Nov 03 –Sept 04**<br><br>**Nov 03 –Sept 04**<br><br>**Nov 03 – Sept 04** | - 12 joint action plans developed by the CS project and MoH health centers every month.<br><br>- Project's supervisors spend 8 days per month in the field.<br><br>- 4 quarterly supervision visits will be conducted during the course of the year 2004 |

**ANNEX D: Concept paper**

**Designated Presenter**: Stephen Amoako, MSA

**Title:** Imam-Centered Family Planning Initiative in Rural West Africa

**Type of Session Preferred**: Round Table

**Submission Category** (Health Programs Outside the Box): (Leadership and Advocacy at the Local Level)

**Learning Objectives:**

**By the end of my presentation, the participant will be able to:**

Identify the asset Imam leadership can bring to a community health program.

Reflect on how Islamic values can improve family planning outcomes.

Critique the conflict that traditional family planning program models can create in rural Africa.

Assess overall best practices for village-centered African family planning programs.

---

**Program Background:**

It was during late 11th Century that large sections of West Africa accepted Islam and integrated its faith practices into village life. Since then a blend of Islam and historical traditions has influenced both cultural and religious norms. It is in this milieu that the Adventist Development and Relief Agency (ADRA) Imam-centered Family Planning Initiative was developed in the Prefecture of Siguiri, Upper Guinea, with funding from the United States Agency for International Development (USAID).

The purpose of the program was to mobilize village religious authority (Imam as religious and tribal leader) to educate both men and women about the importance of responsible and value-defined family planning. The specific program objective was to increase the use of family planning (FP) and reproductive health practices and services.

The initial project planned for two years (April 2001 –March 2003) but with additional follow-on funding the project has been extended until September, 2005.

The original project focused on capacity building with existing health/post staff. Attempts were made to enlist them as agents for information dissemination and education for FP and reproductive health issues. Initially outcomes in the use of FP services and products were positive; yet, not long into the project we started to identify declining trends in impact effectiveness. Investigations conducted by project staff revealed that a Moslem religious leader was preaching against FP indicating it was anti-Islam and was actually circulating his message on audio tapes. There was the need for a prompt and appropriate reaction to the obvious danger. Our response was to implement a new Imam-centered initiative. Under the initiative, the project collaborated with the leadership of the Islamic League of Upper Guinea

to prepare a Koran-based training module. A 25-day training for 144 Imams from all target communities was implemented at a cost of approximately $10,000.

Post-training we found the Imam successfully used their new knowledge within their mosques sermons. Using data collection forms our Islamic project staff monitored the number of FP references during sermons preached by these Imam. Six months after the training and following a number of sermons, the declining patronage of FP services and products gave way to improved outcomes. When compare to base-line data, sales for condoms and pills increased by 15% and 10%. We are confident that our Imam initiative could be replicated in similar contexts in most Moslem communities in Africa and elsewhere the world to empower community health programming.

**Annex E: Pre and post tests questionnaire for the training of religious leaders**

1-
Date
Name
Age
# of spouses
# of children
Occupation
Village
Sub-prefecture

2- Have you ever heard about family planning? Yes No

If yes circle your information source

- Community agents
- Health agents
- Field animators
- Neighbors
- Friends
- Rural Radio
- National/international radios

3-What is family planning? (Choose one answer)

- Births limitations
- Promotion of abortion
- Freedom to choose the size of his family
- Selling of family planning products

4-Which methods of births spacing do you know?

- Pills
- Condom
- Intrauterine device
- Other……..

5- Do you know someone in your area who is using family planning methods? Yes No

- In favor
- Not in favor

6- Have you ever recommended contraceptive methods to someone? Yes No

7-Have you ever used any method to avoid unwanted pregnancy? Yes No

8 Can you write down or list three advantages of family planning?

…….
…….
…….

9. Choose the most correct statements among the three that follow:

- A Muslim must have four spouses
- A Muslim can have four spouses
- A Muslim with limited financial means should not have four spouses

10- Do you think that married couples should talk about births spacing? Yes NO

11-Who is responsible for making the decision of weaning the baby in your family?

12- Write down three Islamic duties of parents for the wellbeing of children

……
……
……

13- What is the breastfeeding duration recommended by Islam? Choose one answer

- 18 months
- 1 year.
- 6 months
- 2 years.
- 40 days
- 30 months

14 – Which advises will you give to a pregnant woman?

……
……
……
……

15- Which advises will you give to a woman after delivery?

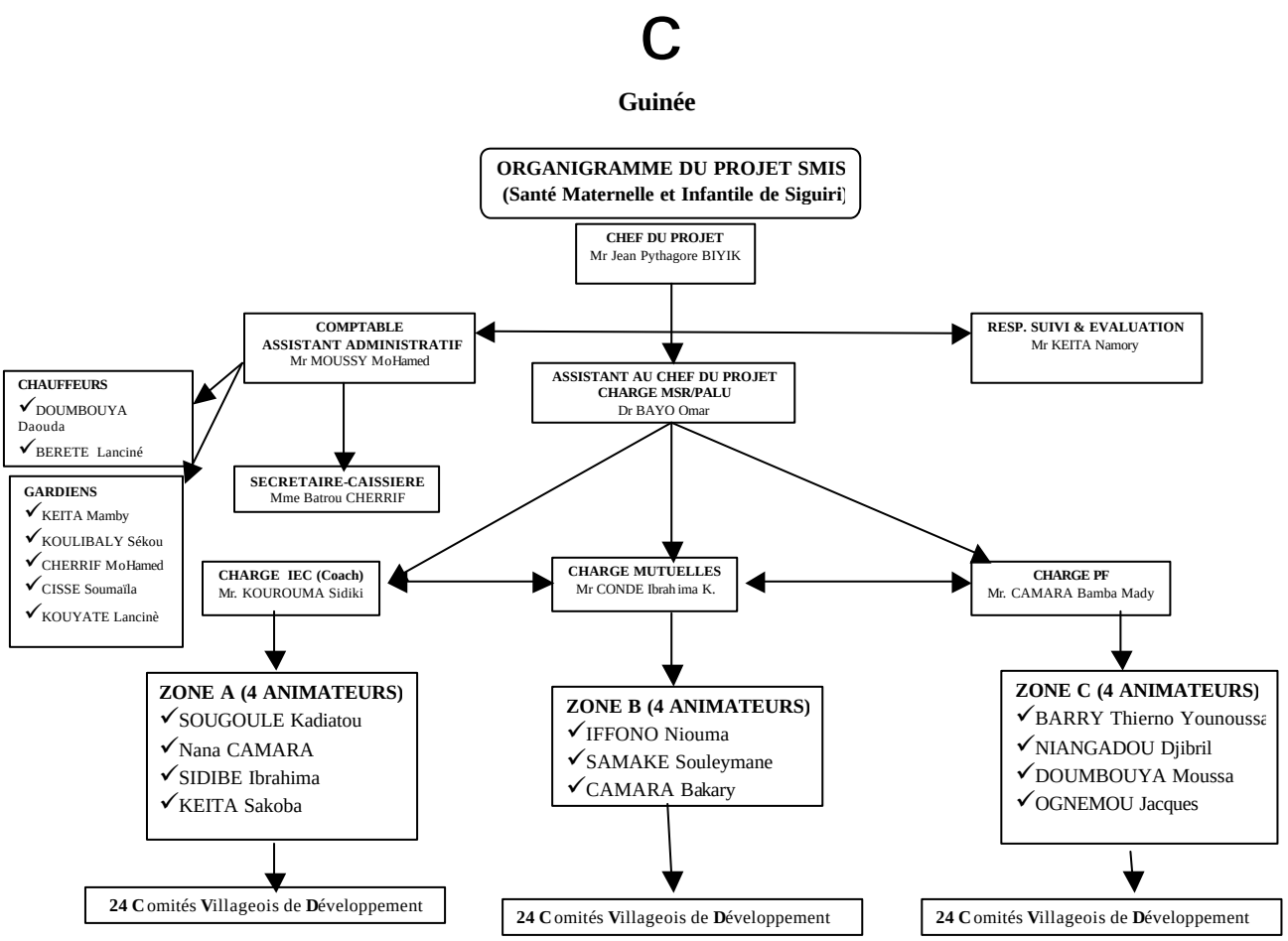
……
……
……
……

16- What is the prophet's recommendation as far as close pregnancies are concerned?

17- What is you gender preference?

- Girls
- Boys
- Both

## Annex F: ADRA Guinea CS organigram



## KPC 2000+ Rapid Catch Indicators <Help>

☐ LQAS ◉ Estimating Confidence Limits ○ Calculating Confidence Limits

| Indicator | Description | Definition | Numerator | Denominator | Percent(calculate) | Confidence Limits |
|---|---|---|---|---|---|---|
| UNDERWEIGHT CHILDREN | Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population) | **Numerator** No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age<br><br>**Denominator** Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6) | 0 | 0 | 0 | ± 0 % |
| BIRTH SPACING | Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child | **Numerator** No. of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth (Rapid CATCH Question<br><br>**Denominator** Number of children age 0-23 months in the survey who have an older sibling | 0 | 0 | 0 | ± 0 % |
| DELIVERY ASSISTANCE | Percentage of children age 0-23 months whose births were attended by skilled health personnel | **Numerator** No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D<br><br>**Denominator** Number of children age 0-23 months in the survey | 2368 | 2944 | 80% | ± 0 % |
| MATERNAL TT | Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child | **Numerator** Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9<br><br>**Denominator** Number of mothers of children age 0-23 months in the survey Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two | 2203 | 2944 | 75% | ± 0 % |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | times') for Rapid CATCH Question 9 Denominator Numerator: Number of mothers of children age 0-23 months in the survey | | | | |
| **EXCLUSIVE BREASTFEEDING** | **Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours** | **Numerator** Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13<br><br>**Denominator** Number of infants age 0-5 months in the survey | 0 | 0 | 0 | ± 0 % |
| **COMPLEMENTARY FEEDING** | **Percentage of infants age 6-9 months receiving breastmilk and complementary foods** | **Numerator** Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13<br><br>**Denominator** Number of infants age 6--9 months in the survey | 0 | 0 | 0 | ± 0 % |
| **FULL VACCINATION** | **Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday** | **Numerator** Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)<br><br>**Denominator** Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14) | 2087 | 2618 | 80% | ± 0 % |
| **MEASLES** | **Percentage of children age 12-23 months who received a measles vaccine** | **Numerator** Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16<br><br>**Denominator** Number of children age 12-23 months in the survey | 1718 | 2618 | 66% | ± 0 % |
| **BEDNETS** | **Percentage of children age 0-23 months who slept under an** | **Numerator** Number of children age 0-23 months with 'child' (response=A) | 0 | 0 | 0 | ± 0 % |

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| | **insecticide-treated bednet the previous night (in malaria-risk areas only)** | mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19<br><br>**Denominator** Number of children age 0-23 months in the survey | | | | |
| **DANGER SIGNS** | **Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment** | **Numerator** Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20<br><br>**Denominator** Number of mothers of children age 0-23 months in the survey | 0 | 0 | 0 | ± 0 % |
| **SICK CHILD** | **Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks** | **Numerator** Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23<br><br>**Denominator** Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21) | 0 | 0 | 0 | ± 0 % |
| **HIV/AIDS** | **Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection** | **Numerator** Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25<br><br>**Denominator** Number of mothers of children age 0-23 months in the survey | 0 | 0 | 0 | ± 0 % |
| **HANDWASHING** | **Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding** | **Numerator** Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26<br><br>**Denominator** Number of mothers of children age 0-23 months in | 0 | 0 | 0 | ± 0 % |

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| | **children, after defecation, and after attending to a child who has defecated** | the survey | | | | |